STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	00	(X3) DATE S COMPL 03/08/	ETED	
	PROVIDER OR SUPPLIER			301 EX	ADDRESS, CITY, STATE, ZIP CODE ECUTIVE DR EL, IN 46032		
				CARIVIL	-L, IN 40032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
R0000	Licensure Survey Investigation of 0 and IN00104821 Complaint IN001 due to lack of evi Complaint IN001 No deficiencies r are cited.	104417 - Unsubstantiated idence. 104821 - Substantiated. related to the allegation  farch 6, 7, and 8, 2012  7 - TC er, RN  1010416 er: 010416 I/A er:	R00	000	The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for the annual and complaint survey completed on 3-8-20. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any relates sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to compowith statutory and regulator requirements. In this document, we have outlined specific actions in response identified issues. We have reprovided a detailed responsito each allegation or finding nor have we identified mitigating factors. We remate committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	r 12. 12. 14 ed s 15 f 19 y 10 not 10 e	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: 3OG811 Facility ID: 010416 If continuation sheet Page 1 of 23

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	00		(X3) DATE SURVEY  COMPLETED		
			A. BUILDING B. WING			03/08/2012	
NAME OF B	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP C	ODE		
				ECUTIVE DR			
	BRIDGE OF CARMI			EL, IN 46032			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE	RECTION HOULD BE	(X5) COMPLETION	
TAG	· ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE			
		dential findings are cited				DATE	
		ith 410 IAC 16.2.					
	in accordance w	ompleted 3/12/12					

State Form Event ID: 30G811 Facility ID: 010416 If continuation sheet Page 2 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		B. WIN			03/08/	2012
			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			301 EX	ECUTIVE DR		
CLARE BRIDGE OF CARME	L LLC		CARME	EL, IN 46032		
(X4) ID SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
·	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0089  410 IAC 16.2-5-1 Administration an Noncompliance (e) An administration work in each licer purposes of this is only be employed (1): (1) health facility; (2) hospital-based at a time. (f) In the administration individual shall be on the administration and record in facility failed to each of the deficient practical facility for five in potential to affect resided in the facility failed to each of the deficient practical facility for five in potential to affect resided in the facility for five in potential to affect resided	ator shall be employed to need health facility. For subsection, an individual can das an administrator in one or d long-term care unit; trator's absence, an e authorized, in writing, to act stor's behalf. review and interview, the employ an Administrator. actice impacted the nonths and had the to 65 of 65 residents who ility.  5 A.M. during entrance ere requested from the ness Director and the esident. Those items are not limited to, "List of name, title, and their cy on residential ontinued stay at	R00		R 089 Administration and Management-Non-complianc What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? The alleged non-compliant practic was cited as having the potential to impact all 65 residents who resided in the community During the 5 month period that elapsed since the 10-17-2011 departure of the previous Administrator the Executive Director from another Brookdale community nearby was assigned by the Regional Vice President to provide immediate oversigns while the recruiting process was initiated. The person in charge of the community was designated as the Health and Wellness Director during the interim period. An Executive Director Pro-Tem was put in	re r, sty	04/07/2012

State Form Event ID: 30G811 Facility ID: 010416 If continuation sheet Page 3 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED		
			B. WING		03/08/2012
	n overnen o			ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	L .		EXECUTIVE DR	
CLARE E	BRIDGE OF CARME	EL LLC		RMEL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	COMPLETION
TAG	AG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	"Contact List."			place on a full-time basis	
				effective November 5, 2011	
	The "Contact Lis	st" included, but was not		through March 8 th , 2012	
		eutive Director: [New		The Indiana State Department	
	-	for] to start on 4/10/12		of Health was notified via n	
		•		on 10-21-11 of all the above	
	-	of Health and Wellness		arrangements · An Execut Director has been hired an	
	Director].			will start on April 10 th , 20	
				The state was notified of th	
	In an interview a	t that time with the		hire as well as the start dat	
	Health and Wells	ness Director, she		This notification was sent	<i>r</i> ia
	indicated the last Administrator left on			e-mail and dated 2-22-12 (p	rior
	October 17, 2011	l, and the facility had		to the survey). How will t	he
	· ·	cutive Director who had		facility identify other reside	<b>I</b>
		She also indicated she did		with the potential to be affe	
	-			by the same alleged deficie	
		nt Health Facility		practice and what corrective	
		icense and was not		action will be taken? • The alleged non-compliant practice.	
	_	d in classes to obtain her		had the potential to affect a	
	Health Facility A	Administrator's license.		residents of the community	
	The Health and V	Wellness Director		During the 5 month period	
	indicated the Ind	iana State Department of		elapsed since the 10-17-20	
	Health was notif	ied of the facility		departure of the previous	
	Administrator va	· ·		Administrator, the Executiv	re
		<b>J</b> ·		Director from another	
				Brookdale community nea	•
				was assigned by the Regio	nal
				Vice President to provide	the
				immediate oversight, while recruiting process was	uie
				initiated. • The person in	
				charge of the community w	vas
				designated as the Health a	
				Wellness Director during th	<b>I</b>
				interim period. · An Execu	<b>I</b>
				Director Pro-Tem was put i	
				place on a full-time basis	
				effective November 5, 2011	

State Form Event ID: 30G811 Facility ID: 010416 If continuation sheet Page 4 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
			B. WIN			03/08/2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				ECUTIVE DR	
CLARE B	RIDGE OF CARME	EL LLC			EL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
				through March 8 th , 2012 $^{\cdot}$		
					The Indiana State Departmen	t
					of Health was notified via ma	il
					on 10-21-11 of all the above	
					arrangements · An Executive	
					Director has been hired and	
					will start on April 10 th , 2012	
					The state was notified of this	
					hire as well as the start date. This notification was sent via	
					e-mail and dated 2-22-12 (price	
					to the survey). What	
					measures will be put in place	,
					or what systemic changes wi	
					the facility make to ensure th	
					alleged deficient practice doe	
					not recur? The new	
					Executive Director for the	
					community will start on	
					4-10-12. · The community wi	II
					notify the ISDH in the event of	of
					any changes in Executive	
					Director within 3 days. In the	•
					event of a future opening of t	he
					Administrator position, an	
					interim will be designated an	
					the ISDH will be notified. How	
					will the corrective actions be monitored to ensure the	
					deficient practice will not rec	ur
					i.e., what quality assurance	ui,
					programs will be put in place	?
					The Regional Vice Preside	•
					will continue to provide	
					operational oversight to this	
					community on a weekly basis	s
					in order to support the new	
					Executive Director. By what	
					date will these systemic	
					changes be implemented?	
					4-7-12	

State Form Event ID: 30G811 Facility ID: 010416 If continuation sheet Page 5 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED		
			A. BUILDING		03/08/2012		
			B. WING	ET ADDRESS CITY STATE ZID CODE			
NAME OF PI	ROVIDER OR SUPPLIER	8		ET ADDRESS, CITY, STATE, ZIP CODE			
CLADE D		-1.1.0	301 EXECUTIVE DR CARMEL, IN 46032				
CLARE B	RIDGE OF CARME	EL LLG	CAR	INEL, IN 46032			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIO	N	
TAG	REGULATORY OR	GULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)		DATE			
R0095	410 IAC 16.2-5-1						
	Administration a	<del>-</del>					
	-Noncompliance						
		at are required under IC					
		mit an Alzheimer's and I care unit disclosure form,					
	•	designate a director for the					
		dementia special care unit.					
		Il have an earned degree					
		onal institution in a health					
	care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons						
		ector for an existing					
		dementia special care unit at					
		tion of this rule are exempt					
	from the degree						
	•	ne director shall have a					
	minimum of twel						
		c training within three (3)					
		employment as the director					
		's and dementia special care					
		nours annually thereafter to: eds or preferences, or both, of					
		ired residents; and					
		anding of the current					
	( ) 0	e for residents with dementia.					
	Based on record	review and interview, the	R0095	R 095 Administration and	04/07/201	12	
	facility failed con	mplete the		What corrective action(s) will be			
	"Alzheimer's/Dementia Special Care			accomplished for those residents			
		•		found to have been affected by the	e		
	impacted 65 of 65 residents who resided						
	•			community's Regional Vice Presid	lent		
	in the facility.			provided the surveyors with a cop	у		
	Findings include	:		"Alzheimer's/Dementia Special Ca			
	-			Unit" disclosure dated 3-6-12. The			
	On 3/6/12 at 10:1	15 A.M. during entrance		potential to affect all 65 residents			
	Based on record facility failed con "Alzheimer's/Der Unit" disclosure. impacted 65 of 6 in the facility.  Findings include	review and interview, the mplete the mentia Special Care  The deficient practice is residents who resided	R0095	Management-Non-compliance What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? On 3-7-12 at 9 am, the community's Regional Vice Presid provided the surveyors with a cop of the completed "Alzheimer's/Dementia Special Ca Unit" disclosure dated 3-6-12. The survey reports this oversight had to	e lent y re e	20	

State Form Event ID: 3OG811 Facility ID: 010416 If continuation sheet Page 6 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
			B. WING			03/08	/2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ECUTIVE DR		
CLARE E	BRIDGE OF CARME	EL LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	s were requested from the			the community.		
	"Entrance Confe	rence Checklist" from the					
	Health and Welli	ness Director and the			How will the facility identify other		
	Regional Vice Pr	resident.			residents with the potential to be affected by the same alleged	9	
					deficient practice and what corre	ective	
	On 3/6/12 at 11:1	15 A.M., the Health and			action will be taken?		
	Wellness Directo	or provided the "Policy on			The appropriate documentation was immediately		
		tance and continued stay			completed and provided to the		
		l" dated 7/2003. The			surveyors on 3-7-12.		
	policy included, but was not limited to, "The community may admit and retain adults who meet the following criteria: Can exhibit signs of confusion and				This paperwork will be completed annually as requested	1	
					Completed aimany as requested	<i>.</i>	
					What measures will be put in pla	ce or	
	1				what systemic changes will the		
	forgetfulness, an	d benaviors			facility make to ensure the allege		
					deficient practice does not recur  The Executive Director w		
		ing interview, the			notified of the annual requiremen		
	~	resident and Health and			and will be responsible for		
		or indicated the facility is			completion of the appropriate documentation annually.		
		" facility and all residents			· This education will be		
	have a diagnosis	of dementia.			provided to the new Executive		
					Director by the RVP and / or Designee.		
	On 3/6/12 at 2:00	P.M. during daily exit					
	conference, the f	acility			How will the corrective actions b		
	"Alzheimer's/De	mentia Special Care			monitored to ensure the deficient practice will not recur, i.e., what	ι	
	Unit" disclosure	was requested.			quality assurance programs will	be	
					put in place?	am4	
	On 3/7/12 at 9:00	A.M., the facility			The Regional Vice Presid will audit for the completion of the		
		resident provided an			required form annually and will	-	
	_	mentia Special Care			review the document prior to submission annually as well as	with	
	Unit" disclosure	_			any changes in licensure.	WILII	
	The "Alzheimer's	s/Dementia Special Care			By what date will these systemic		
		2 included, but was not			changes be implemented?	•	
		e unit lockedyes, Does			· 4-7-12		
	minicu to, is the	unit lockedyes, Does					

State Form Event ID: 3OG811 Facility ID: 010416 If continuation sheet Page 7 of 23

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING  B. WING	00	COMPLETED 03/08/2012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
	BRIDGE OF CARME			ECUTIVE DR EL, IN 46032	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	features yes, De Alzheimer's/Dem have activity staft to that program/u In an interview 3 Regional Vice Pr facility had never document because considered a "Me therefore she did	nentia care program/unit if dedicated exclusively unit yes"  /7/12 at 9:00 A.M., the resident, she indicated the recompleted the above se the entire facility was emory Care" unit			

State Form Event ID: 30G811 Facility ID: 010416 If continuation sheet Page 8 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLI			ETED	
			B. WING 03/08/2012			2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ECUTIVE DR		
CLADER	RIDGE OF CARME	ELLI C			EL, IN 46032		
OLAINE D	INDUL OF CANVIL			CAINIL			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG DEFICIENCY)			DATE
R0144	(a) The facility sh a state of good re	afety Standards - Deficiency nall be clean, orderly, and in epair, both inside and out, e reasonable comfort for all					
	residents.						
	Based on observa	ation and interview, the	R01	44	R 144 Sanitation and		04/07/2012
	facility failed to	maintain shower grab			Safety-Deficiency What corrective action(s) will be		
	bars in safe cond	ition for 2 of 14			accomplished for those residents		
	resident's enviror	ment observed out of 56			found to have been affected by the	•	
	resident showers	. [Resident #44 and			alleged deficient practice?		
	Resident #27 sho	-			The community makes every effort		
	Findings include	•			be clean, orderly, and in a good sta of repair, in order to provide a reasonable level of comfort for our residents.		
	During the enviro	onmental tour of the			Resident # 44: Grab bar in shower has been repaired.	the	
	Trains and Trave	ls neighborhood of			Resident # 27: Grab bar ha	s	
	facility on 3/7/12	at 9:50 A.M. with the			been repaired.		
	Maintenance Dir	ector, in the room for					
		e shower was observed to			How will the facility identify other residents with the potential to be		
	-	ab bar. The grab bar was			affected by the same alleged		
	_	end and when grabbed			deficient practice and what correct action will be taken?	tive	
	with hand and we	eight put onto it, the bar			The alleged deficient practic	ce	
	came off of the h	inge it was secured to.			has the potential to affect all		
	The Maintenance	e Director indicated at			residents within the community.  The Maintenance Director h	26	
	this time that he	had not received any			been provided with information	.a3	
		ets that informed him			regarding the required preventativ	e	
	that the shower b				maintenance checks of the community.		
		ur was oronom.			· The Maintenance Director w	/ill	
	During the tour o	of the All Sports			now have a designated binder		
	_	10:30 A.M., the room for			labeled "Work Orders". As each		
	_				work order is completed, the work order will be signed by the person		
		l a broken grab handle			completing the repair.		
		The end of the grab bar			Associates have been		
		ared to wall was broken			provided training on how to comple		
	and had a jagged	edge poking out of the			a work order in the event an item in	1	

State Form Event ID: 30G811 Facility ID: 010416 If continuation sheet Page 9 of 23

ľ	I) PROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		B. WING		03/08/2012	
NAME OF PROVIDER OR SUPPLIER  CLARE BRIDGE OF CARMEL	LLC	301 EX	ADDRESS, CITY, STATE, ZIP CODE (ECUTIVE DR EL, IN 46032		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PERCEDED BY FULL  C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Director at 10:30 A indicated he was not these resident room that needed addres	with the Maintenance A.M. on 3/7/12, he ot aware that either of his had any concerns sed. At this time, a		replacement or repair.  Work order forms will be ke in a designated area of the community in order to document requests by residents and/or family members.	y	
request of any info documentation rela procedure related t	ormation or ating to the policy/ o communication of was given. As of exit		What measures will be put in place what systemic changes will the facility make to ensure the alleged deficient practice does not recur?  The Maintenance Director wow have a designated binder labeled "Work Orders".  A manager will be designated to make rounds on a daily basis ar report any items in need of repair, utilizing a "work order" form.  Other associates will be encouraged to put any findings in writing and place a "work order" request form in the Maintenance Director's Work Order Binder.  As each work order is completed, the work order will be signed by the person completing to repair.  Work order forms will be keen a designated area of the community in order to document responses and requests by resider and/or family members.  How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?  The Executive Director/Designee will audit the woorder binder weekly.	vill ed nd he ept nts	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 03/08/2012		
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE ECUTIVE DR	=======================================		
CLARE B	RIDGE OF CARMI	EL LLC	CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	TON (X5) D BE COMPLETION OPRIATE DATE		
				weekly basis. The Executive Director responsible for prioritizing ne repairs.			
				By what date will these syster changes be implemented? · 4-7-12	mic		

State Form Event ID: 3OG811 Facility ID: 010416 If continuation sheet Page 11 of 23

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	INSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPL	ETED
			B. WING		<del></del>	03/08/	2012
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			ECUTIVE DR		
CLARE B	RIDGE OF CARME	FLLIC			EL, IN 46032		
,							
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0148	(e) The facility st grounds, and eq in good repair, a adversely affect residents or the (1) Each facility sa written program the continued up (2) The electrical appliances, cord sources, fire alar shall be maintain functioning and collectrical codes. (3) All plumbing comply with state (4) At least yearl systems shall be Based on observing facility failed to potentially hazar residents with collectrical to affect residents residing [Residents #27, #Findings include]  During the environt the procedure of Brookdale Serving In ground the potential to affect residents and the of Brookdale Serving In ground the ground the procedure of Brookdale Serving In ground the gr	afety Standards - Deficiency hall maintain buildings, uipment in a clean condition, nd free of hazards that may the health and welfare of the public as follows: shall establish and implement in for maintenance to ensure skeep of the facility. I system, including s, switches, alternate power in and detection systems, ned to guarantee safe compliance with state shall function properly and e plumbing codes. y, heating and ventilating inspected. action and interview, the keep the facility free of dous materials for onfusion. This affected 3 and out of a total of 56 confused in facility. This had the set 65 of 65 confused in facility.	R014	48	R 148 Sanitation and Safety-Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? The community makes every effort keep the community free of potentially hazardous materials for residents with confusion.  The Sunroom closet door h been emptied of any sharp items.  Items, such as nail polish, a kept in an area that is out of reach residents, and accessible only to associates.  Resident #27: Disposable razor was immediately removed fro the vanity and disposed of in a sharps container located in the secured laundry room. Replaceme razor is stored in a locked cabinet the resident's apartment.	as are to	04/07/2012
		k, as well as other sharp			Resident # 48: The disposable razor, Body wash and		
	and barbeque for	k, as well as outer straip	ı		aisposable lazoi, bouy wasii allu		ĺ

State Form Event ID: 3OG811 Facility ID: 010416 If continuation sheet Page 12 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLI	ETED
			B. WIN			03/08/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			ECUTIVE DR		
CLARE	BRIDGE OF CARME	ELLIC			EL, IN 46032		
OLAINE I	TINDGE OF CARWIN			CAINIL	_L, IN 40032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	items was found	unlocked. During an			shaving cream were placed in a locked cabinet.		
	interview at that	time, the Maintenance			Resident #33: The two		
	Director indicate	ed the Sun Room closet			alcohol swabs, medium sized safet	ty	
	door should be lo	ocked			pin, 6 tubes of lipstick, and 2 bottle	-	
	door should be h	ocked.			of nail polish were removed.		
	D : 41 .						
	_	of the Collegiate Sports			How will the facility identify other		
	_	9:15 A.M., in the			residents with the potential to be		
	kitchenette area	there was a bottle of nail			affected by the same alleged		
	polish found in a	n unlocked drawer. The			deficient practice and what correct action will be taken?	uve	
	Maintenance Dir	rector indicated at this	Residents in the community		,		
		not be in an unlocked			who may not be able to recognize t	1	
	drawer.	iot be in an unioeked			proper use of personal care items		
	drawer.				have the potential to be affected by	<i>'</i>	
					the alleged deficient practice.		
	During the tour of	of the Trains and Travel			Associates were re-educate regarding the "Personal Care Items		
	neighborhood at	9:50 A.M., the room for			policy, in order to help them identif		
	Resident # 27. w	vas found to have a			items which could present a poten		
		in the mirror vanity.			safety risk to such residents. Larg		
	•	ed in an interview at 9:53			quantities of personal care produc will be kept in a locked cabinet or	ts	
					drawer.		
		zors are kept in nurses					
	office and then a	after they are used on a					
	resident, they are	e to be disposed of in the			What measures will be put in place	or	
	sharps container	which is inside the			what systemic changes will the		
	-	at is secured with a keyed			facility make to ensure the alleged		
	,	ated they should not be in			deficient practice does not recur?		
	-	-			The nurse assigned to each floor of the community will be	1	
		om in the mirror cabinet,			responsible for completing rounds	at	
	1	room they should be kept			the start of each shift in order to		
	in the locked cab	oinet.			audit for compliance with the abov	е	
					policy.		
	During the tour of	of the All Sports			How will the corrective actions be		
		10:55 A.M., the room for			monitored to ensure the deficient		
	_	ne cabinet in the bathroom			practice will not recur, i.e., what		
	•				quality assurance programs will be	•	
		unlocked on one side.			put in place?  Results of audits will be		
		ked portion of cabinet			communicated to the Executive		
	within reach then	re were the following			Director/Health and Wellness		

State Form Event ID: 3OG811 Facility ID: 010416 If continuation sheet Page 13 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
			B. WING			03/08/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ECUTIVE DR		
CLARE E	BRIDGE OF CARME	EL LLC			EL, IN 46032		
					,	ı	(715)
(X4) ID PREFIX				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	Director/Designee on a weekly bas	io	DATE
	_	e razor, 3- 32 oz. bottles			The Executive Director/Hea		
	_	wash, which the label			and Wellness Director will take		
	indicated "for ex	ternal use only". One 11			appropriate corrective actions, bas	ed	
	ounce can of sha	ving creme which the			on findings. Such action may		
	label indicated, "	keep out of reach of			include counseling, disciplinary action, up to and including		
	children".	•			termination of the associate		
					responsible, in the event		
	During the tour	of the Antique Toys			non-compliance is noted.		
	_	• •					
		11:05 A.M., the room for			By what date will these systemic		
	-	e cabinet in the bathroom			changes be implemented?		
	was found to be	unlocked. Inside the			4-7-12		
	unlocked portion	of cabinet within reach					
	there were the fo	ollowing items: 2					
	-Alcohol swabs,	one medium sized safety					
		pstick, and 2 bottles of					
		alcohol swabs indicated					
	_						
		nol 70% External Use					
	Only".						
	Upon completion	n of tour at 11:30 A. M,					
	after discussing	the items found in the					
	resident areas, a	request was given to the					
		resident for the policy					
	regarding person						
	0 01	7/12 at 1:55 P.M. The					
	following policy	was provided.					
	1 1	esident Personal Care					
	Items dated 11/2	011, indicated, "Some					
	residents are not	able to recognize how all					
	personal care ite	ms or toiletries are to be					
	properly used. T						
		nwash, liquid or bar soap,					
	_						
	snampoo, cologr	ne, perfume, body splash,					

State Form Event ID: 3OG811 Facility ID: 010416 If continuation sheet Page 14 of 23

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	COMPLETED  03/08/2012
		B. WING		03/00/2012
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE	
CLARE	BRIDGE OF CARMEL LLC		ECUTIVE DR EL, IN 46032	
		ID		(VE)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
	razors, lotions, makeup, shaving cream,			
	nail care items, etc. These items can			
	present a safety risk if they are consumed			
	or used inappropriately. As residents do			
	move freely throughout the community,			
	including into rooms of other residents at			
	times, it is important that all areas of the			
	community are made as safe as possible.			
	This includes bath areas as well as			
	resident rooms Policy Detail Do not			
	keep large quantities of liquid care			
	products out and available to residents			
	where they can mistakenly be ingested.			
	Large quantities of liquid care			
	productsused in the shower room must			
	be stored in a locked cabinetTooth			
	pastemakeup, shaving cream, nail care			
	itemson the stop shelf of closet where it			
	is out of view and reach of most			
	residentsAll items labeled, 'keep out of			
	reach of children' <i>and</i> razors must be			
	stored in a locked drawer or cabinet"			
	Clare Bridge of Carmel had an admission			
	policy dated 7/2003, which indicated,			
	"Admission Criteria. The community			
	may admit and retain adults who meet the			
	following criteria: a) Can exhibit signs of			
	confusion and forgetfulness, and			
	behaviorsb) Can exhibit wandering			
	behavior;"			
l .	1	ı		

State Form Event ID: 3OG811 Facility ID: 010416 If continuation sheet Page 15 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
			A. BUII			03/08/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
CLADED		1116			ECUTIVE DR		
CLARE B	RIDGE OF CARME	EL LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0154	(k) The facility shareas, common of utensils clean, from and maintained if with 410 IAC 7-2. Based on observations facility failed to 1 clean for 1 of 1 k potential to affect	afety Standards - Deficiency hall keep all kitchens, kitchen dining areas, equipment, and ee from litter and rubbish, in good repair in accordance 4. Attion and interview, the keep the ice machine hitchens. This had the titchens that duids from the kitchen.	R01	54	R 154 Sanitation and Safety Standards-Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?  Ice machine located in the kitchen was cleaned within minutes of the finding.		04/07/2012
	A.M., the ice may have brown splat both sides of the machine.  In an interview of the Director of Director of Director of Director was. He in	on 3/6/12 at 9:51 A.M., Vining Services (DDS) not know what the dried dicated they clean the ice of, but he was not certain			How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what correct action will be taken?  In order to prevent an adveroutcome to any residents in the community, the Dietary Manager haprovided education to dining staff associates on the methods and standards for appropriate cleaning schedule for the ice machine.  The ice machine will be checked for cleanliness every shift and a cleaning "schedule" will be pinto place by the Dietary Manager.	rse as :: ::	
	schedule for all of February to curred DDS provided a 10 A.M., there we designated for the	ade for the cleaning of the kitchen for ent date at this time. The cleaning list on 3/7/12 at ras no task on the list e cleaning of the ice was no more information			What measures will be put in place what systemic changes will the facility make to ensure the alleged deficient practice does not recur?  A daily/monthly cleaning chas been posted at the side of the machine.  Every four weeks the machiwill be emptied, cleaned, sanitized and recorded.  These cleaning records will	art ice ine	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		03/08/2012	
	PROVIDER OR SUPPLIER		301 EX	ADDRESS, CITY, STATE, ZIP CODE KECUTIVE DR EL, IN 46032	•	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROWING BY AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	provided as to th	e cleaning of the ice		monitored and kept on file by the		
	machine.			Director of Dining Services.		
	macnine.			How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will b put in place?  The Dietary Services Mana will provide copies of all audits to Executive Director on a monthly basis.  In the event non-compliant noted, the Executive Director will responsible for directing corrective action for the Dietary Department.  By what date will these systemic changes be implemented?  4-7-12	e ger the ce is be e	

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED
			B. WING	<del></del>	03/08/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	1		ECUTIVE DR	
CLADE D	RIDGE OF CARME	=1.11.0		EL, IN 46032	
CLARE B	RIDGE OF CARIVIE		CARIVII	EL, IN 40032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R0217	410 IAC 16.2-5-2				
	Evaluation - Defi	_			
		mpletion of an evaluation, the			
		propriately trained staff			
		dentify and document the			
	follows:	ovided by the facility, as			
		offered to the individual			
	• •	appropriate to the:			
	(A) scope;	appropriate to the			
	(B) frequency;				
	(C) need; and				
	(D) preference;				
	of the resident.				
	` '	offered shall be reviewed			
		ppropriate and discussed by			
		facility as needs or desires			
		ne facility or the resident may			
	request a service	ipon service plan shall be			
		d by the resident, and a copy			
	•	an shall be given to the			
	resident upon re	<u> </u>			
	•	ion and documentation of			
		d is needed if evaluations			
	subsequent to th	e initial evaluation indicate			
	no need for a ch	ange in services.			
	• •	ion of medications or the			
		dential nursing services, or			
		a licensed nurse shall be			
		ification and documentation			
	of the services to	•	D0217	D 047 Evaluation Deficiency	04/07/2012
		review and interview, the	R0217	R 217 Evaluation-Deficiency What corrective action(s) will be	04/07/2012
	•	obtain the signature of		accomplished for those residents	
	the resident or re	sident's legal		found to have been affected by the	,
	representative or	the initial service plan		alleged deficient practice?	
	-	esident #35] and an		Resident #35: Responsible party has been contacted to obtain	
	-	olan for 1 resident		the appropriate signatures on the	
				current Personal Service Plan.	
		The deficient practice		Resident #23: A care plan	
	impacted 2 of 8 i	residents reviewed for		meeting was held with the Health a	nd
			1	I .	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) I			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED
			A. BUI. B. WIN			03/08/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l .
NAME OF P	PROVIDER OR SUPPLIEF	₹			ECUTIVE DR	
CLARE F	BRIDGE OF CARMI	FLLIC			EL, IN 46032	
					1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		DATE
	service plans in	a sample of 8.			Wellness Director, Resident Care Coordinator, and the resident's	
					responsible parties. A signature w	/as
	Findings include	<b>:</b>			obtained to indicate their agreeme	nt
					with the current Personal Service Plan.	
	1. On 3/7/12 at	1:30 P.M., Resident #35's				
	record was revie	·			11	
		ere not limited to,			How will the facility identify other residents with the potential to be	
	dementia, atrial	·			affected by the same alleged	
		esident #35's admission			deficient practice and what correct	tive
	or "Move - In" d				action will be taken?	
	or wrove - in a	ate was 2/10/12.			New move-ins who require Personal Service Plans, as well as	
					current residents have the potential	
		vice Plan" dated 2/10/12			to be affected by the alleged defici	ent
		"Signature of Legal			practice.  Corrective actions will inclu	ıdo
	Resident/Legal I	Representative;" however,			implementation of a new	ide
	included "Mailed	d to Family."			documentation system, which will	
					allow for the Health and Wellness	- f
	On 3/7/12 at 3:4	5 P.M., the signed			Director/Designee to bring a copy the signature page to each Care Pl	
		plan for Resident #35			meeting. Names of all parties	
	1 ^	om the Health and			attending will be documented in the record. Signatures will be obtained	
	Wellness Directo				at the time of each meeting and	u
	Weiliness Bireck				indicated on this page.	
	In an interview :	on 3/8/12 at 9:30 A.M.			In the event it is inconvenie	
					for the responsible party to attend care conference in-person,	a
		and Wellness Director,			significant changes and updates to	o
		e facility did not have a			the Personal Service Plan will be	
	1	Resident #35's personal			discussed via phone with the responsible party, e-mailed or	
	service plan.				mailed to the responsible party for	
					signature. The disposition for	
	2. On 3/6/12 at	12:40 P.M., Resident			signatures will be noted on the Personal Service Plan.	
	#23's record was	reviewed. Diagnoses			Resident Personal Service	
	included, but we	re not limited to, heart			Plans completed going forward wil	
	disease, hyperter	nsion, depression,			utilize the new audit /tracking tool monitor for completion of the	to
	Alzheimer's/Den	nentia, and diabetes			signature page.	
		Admission or "Move -				
	In' date was 1/5/					
	111 446 1145 1/3/		1		1	

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY  COMPLETED  03/08/2012
	PROVIDER OR SUPPLIER  BRIDGE OF CARMEL LLC	STREET ADDRESS, CITY, STATE, Z 301 EXECUTIVE DR CARMEL, IN 46032	AP CODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO DEFICIENCE)	ON SHOULD BE COMPLETION THE APPROPRIATE
	A "Personal Service Plan" dated 2/3/12 was completed related to the addition of home health services. The "Personal Service Plan" included, but was not limited to, "Service Coordination: Resident [#23] is using Physical Therapy services /Occupational Therapy services and Home Health services"  The "Signature of Resident/Legal Representative" was blank.  On 3/7/12 at 3:45 P.M., the signed personal service plan for Resident #23 was requested from the Health and Wellness Director.  In an interview on 3/8/12 at 9:45 A.M., the Health and Wellness Director indicated the family forgot to sign the new service plan after the care meeting on 2/9/12.	What measures will be what systemic change facility make to ensure deficient practice does. In the event the Service Plan has been signature and more the elapsed, the Health and Director / Designee will a copy of the documer reflecting this will be publicated record file along Personal Service Plant.  How will the corrective monitored to ensure the practice will not recur quality assurance proput in place?  The Health and Director/Designee will results to the Executive Director/Designee mon additional changes in required, they will be a implemented by the Quality the community.  By what date will these changes be implemented to 4-7-12	s will the e the alleged s not recur? e Personal e sent for an 7 days has ed Wellness Il re-send, and entation colaced in the eng with the .  e actions be the deficient e, i.e., what grams will be I Wellness report audit re enthly. If this system are developed and A process of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULT		ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
				B. WING		03/08/2	2012
	STREET ADDRESS, CITY, STATE, ZIP CODE						
NAME OF P	ROVIDER OR SUPPLIER	-			ECUTIVE DR		
CLARE BRIDGE OF CARMEL LLC				EL, IN 46032			
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	1	DATE
R0299	410 IAC 16.2-5-6	Services - Noncompliance					
	(3) The medicati	•					
	· '	s, and notification of the					
		essary, shall be documented					
		th the facility 's policy.					
	Based on record	review and interview, the	R02	299	Noncompliance What		04/07/2012
		respond to a pharmacy			corrective action(s) will be		
	recommendation				accomplished for those		
		deficient practice			residents found to have been	1	
		residents reviewed for			affected by the alleged deficient practice? Resider	- <b>4</b>	
	•				#23: The physician was agai		
		mendations in a sample			shown the pharmacy	"	
	of 8. [Resident #	<sup>‡</sup> 23]			recommendation, and has		
					signed indicating disagreeme	ent	
	Findings include	:			with the recommendation.		
					How will the facility identify	,	
	On 3/6/12 at 12:4	40 P.M., Resident #23's			other residents with the		
	record was review	wed. Diagnoses			potential to be affected by th		
	included, but we	re not limited to, heart			same alleged deficient practi and what corrective action w		
	disease, hyperten	sion, depression,			be taken? Other residents	"	
		nentia, and diabetes			who receive pharmacy		
	mellitus type II.				recommendations have the		
	momous type m.				potential to be affected by the	е	
	A "Dhycician's M	Iedication Orders"			alleged non-compliant practi		
	,				· Pharmacy Recommendatio	ns	
		22/12 for 3/12 included,			will be routinely shared with		
		ited to, "Mirtazapine 15			the physician who is		
		1 tablet orally daily at			encouraged to indicate		
	bedtime as neede	ed for			whether or not there is agreement with the pharmac	,	
	depression/insom	nnia, start date 1/5/12"			recommendation. The	y	
					community will continue to		
	A "Medication A	dministration Record"			routinely share the		
		uded, but was not limited			recommendations and reque	st	
		15 milligrams dose			a signature. What measure		
	•	at 11:00 P.M. and			will be put in place or what		
	_				systemic changes will the		
	1/19/12 at 12:00	A.M no doses were			facility make to ensure the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPLI	
			B. WING	ì		03/08/	2012
NAME OF I			<del>'</del>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIER	L		301 EXE	ECUTIVE DR		
CLARE E	BRIDGE OF CARME	EL LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	recorded on the 2	2/12 or 3/12 MAR.			alleged deficient practice doe	es	
					not recur? Nurses have		
	A "Consultation	Report" dated 1/10/12			been re-educated on		
	included, but wa	-			communicating with		
		on: Please re-evaluate the			physicians related to pharma recommendations. In some	icy	
		order for mirtazapine,			cases, if it is the preference of	<sub>\f</sub>	
		•			the physician, these	·	
	1 ^	nuing its use Physician			recommendations will be fax	ed	
	Response bland	K'			to the physician for a respon		
					and at other times, based on		
	In an interview of	on 3/8/12 at 11:00 A.M.,			physician preference, the		
	the Health and W	Vellness Director			recommendation will be place	ed	
	indicated she giv	res all recommendations			in the physician folder in the		
	to the physician;	however, the physician			wellness center, while awaiting	ng	
	doesn't always si				a physician decision. The		
	account and ay 5 51	.Sir them.			Nurse Designee will be		
	Om 2/9/12 at 2:00	ODM the facility policy			responsible for following up		
		O P.M., the facility policy			on any pharmacy recommendations, assuring		
	and procedure fo	•			the response is appropriately		
	recommendation				documented and the order	'	
		requested from the			implemented. The commun	ity	
	Health and Wells	ness Director. At that			no longer employs the service		
	time, the Health	and Wellness Director			of the physician who neglect		
	indicated the fac	ility did not have a policy			to sign the recommendation.		
		acy recommendations			How will the corrective		
	and physician no	•			actions be monitored to ensu		
	p.i., ore air ne				the deficient practice will not		
					recur, i.e., what quality		
					assurance programs will be pin place? • The Health and	out	
					Wellness Director/Designee		
					will audit physician complian	ce	
					with signing the forms on a	- =	
					monthly basis. The Executiv	e	
					Director will be informed of the		
					results of these compliance		
					audits on a monthly basis.	In	
					the event a physician is		

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		03/08/2012
NAME OF P	DOMNED OF GUIDNI 155	,	STREET .	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER		301 EX	ECUTIVE DR	
	BRIDGE OF CARME			EL, IN 46032	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
mo	REGULTION ON	ZZE ZZETA TATO EN ONIBETION)	1710	non-compliant with signing recommendations, the	
				Executive Director will be	
				notified, and will seek the assistance of the new medic	al le
				director when indicated. By	ai
				what date will these systemi	ic
				changes be implemented?	
				4-7-12	
			I	1	

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